Commonwealth of Kentucky
Cabinet for Health and Family Services (CHFS)
Department for Community Based Services (DCBS)
Division of Child Care (DCC)

Kentucky Integrated Child Care System (KICCS) Provider Portal Access Agreement

Form Instructions

General Procedure

- The user should go to the Provider Portal Request Account Web site https://portalrequest.chfs.ky.gov/ and complete the Provider Portal Account Request form online.

- After completing the form online, the user will receive an email to confirm their online request has been submitted. Print the confirmation to send with application.

- One form must be submitted for each user requesting an account.

- If the provider user applicant is also applying as provider administrator and is not the head of the organization or owner, the owner of the organization must sign the second signature line, attesting that the applicant is identified correctly in Section 1.

- ALL fields must be completed. Handwritten information must be legible**.** Access will not be granted if the user information is incomplete or illegible when the form is submitted.

- When the request is approved by the Child Care Assistance Program (CCAP) administrator, the requesting user will receive another email with the assigned account information.

- The completed application, copy of the driver's license or valid photo ID issued by the state, and the printout from Web application verifying request number should be submitted electronically at fax number 502-564-3464 or by email to: Portal.Access@ky.gov . **IMPORTANT:** Please enlarge and lighten your driver's license before faxing it to make the image easier to read.

- If you prefer, you may mail these documents to: Division of Child Care, 275 E. Main St, 3C-F, Frankfort, KY 40621, ATTN: CCAP Portal Administrator.

For questions concerning the application process, please contact CCAP administrator at (502) 564-2524.

For questions concerning accessing the Provider Portal Access Request Account call the help desk at (502) 564-0104, option 6 or toll free at 866-231-0003 Option 6.

Detailed Procedure for Entries on the Form

- Enter the date request completed on the website.
- Enter Request Number from website confirmation.
- Enter access needed based on following function description:
  - **Provider Administrator** identifies and assigns tasks to the Provider User(s). A Provider Administrator is also assigned as a Provider User. Provider Administrators are set up by the CCAP administrator.
  - **Provider User** completes tasks assigned to them by the Provider Administrator, such as view PBFs, save PBFs, send PBFs, print PBFs, print remittance. Provider Users request for access must be approved by the Provider Administrator.
- Enter applicant's first name, middle initial and last name.
- Enter email address of the referrer (Provider Administrator if approved access by CCAP administrator) and email address of the individual requesting access. The individual may be a provider user and/or a provider administrator.
- Enter primary phone number which may be home and/or business phone number.
- Enter secondary phone number if available where applicant can be contacted.
- Enter Name of Head of Organization and/or the business owner's full name.
- Enter the business name if different from head of organization or business owner.
- Enter the business fax number.
- Enter CLRs associated with the business and applicant.
- Enter business address where mail is received.
- Enter actual location for the business.
- Applicant reads Section 2 User agreement statement and indicates that they will adhere to the terms as a user of the provider portal.
- All user applicants must sign Section 3, first line. If the applicant is user only, the provider administrator is required to sign on the second line. If the applicant is provider administrator, sign first line and owner/head of organization signs the second line.

- **ALL** signatures must be original. We will not permit anyone to sign for another person. Clear signatures must be provided. Access will not be granted if signatures are missing or names are illegible.

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This form must be completed and returned to access KICCS Provider Portal Account. It must be completed in ink or typed. All information must be accurate and complete, and the form must contain the appropriate authorized signature(s). When the form is completed, it SHOULD BE submitted electronically for approval to CHFS at fax number – 502-564-3464 or emailed to: Portal.Access@ky.gov. If you prefer, you may mail these documents to: Division of Child Care, 275 E. Main St, 3C-F, Frankfort, KY 40621, ATTN: CCAP Portal Administrator.

SECTION 1: USER INFORMATION

REQUEST DATE: _____ **REQUEST NUMBER:** _____ **OR CIT USER NAME** _____

TYPE OF ACCESS REQUIRED: ( ) PROVIDER USER ( ) PROVIDER ADMINISTRATOR

FIRST NAME: _____ **M.I.** _____ **LAST NAME:** _____

EMAIL: REFERRER_____ **INDIVIDUAL:**_____

PRIMARY PHONE: (____)_____ **SECONDARY PHONE:** (___)_____

HEAD OF ORGANIZATION/OWNER: _____

BUSINESS NAME:_____ **FAX NUMBER:** _____

CLR#(S): _____

BUSINESS MAILING ADDRESS: _____

CITY: _____**STATE** _____ **ZIP:** _____**COUNTY**:_____

SECTION 2: KICCS PROVIDER PORTAL ACCOUNT USER AGREEMENT

By accepting this user agreement, I acknowledge that I have been made aware of my responsibilities to protect the confidentiality of the information in the KICCS Provider Portal Account. I am only permitted to use KICCS Provider Portal Account for the purpose of reporting child care activity for payment through the Division of Child Care in Kentucky. I acknowledge that I have been made aware that misuse of the information may potentially lead to penalties and/or system revocation.

As an authorized user, I agree to the following terms of use:

1. I agree to make only authorized use of any information in the KICCS Provider Portal Account. I agree to not divulge the contents of any record except as permitted by state or federal law.
2. I agree to not share any user name or password information. I acknowledge that I am responsible for any actions taken on the KICCS Provider Portal Account under my login name.
3. I agree not to access the information contained in the KICCS Provider Portal Account other than for authorized business actions.
4. I agree to terminate my access to the KICCS Provider Portal Account when my employment with the reporting entity ends or when my job responsibilities no longer require me to access KICCS Provider Portal Account information.
5. I agree to immediately report any misuse of the KICCS Provider Portal Account or violations of this agreement to the Department for Community Based Services or the CHFS IT Security Officer.

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Any misuse of the KICCS Provider Portal Account or its information may lead to temporary revocation of access privileges, permanent loss of access privileges or penalties under state and/or federal law.

SECTION 3: AUTHORIZATION SIGNATURE FOR ALL ACCOUNT REQUESTORS

I attest to the best of my knowledge that the information provided above is true, accurate, and complete and that I have read and agree to the KICCS Provider Portal Account user agreement on page 1 of this document.

► _____ ► _____

PROVIDER USER SIGNATURE **DATE**

Print Name *(must be legible):* _____

► _____ ► _____

PROVIDER ADMINISTRATOR OR HEAD OF ORGANIZATION/OWNER **DATE**

Print Name *(must be legible):* _____

SECTION 4: AUTHORIZATION SIGNATURE(S) FOR CCAP ADMINISTRATORS ONLY

I certify that the job duties of the User requires access to the program(s) requested and that the access complies with appropriate use as specified in the KICCS Provider Portal Account User Agreement.

CCAP ADMINISTRATOR: _____ **DATE:** _____

FOR DEPARTMENT FOR COMMUNITY BASED SERVICES USE ONLY

DATE REQUEST RECEIVED: _____ DATE USER AGREEMENT RECEIVED : _____

DATE COPY OF DRIVER'S LICENSE OR VALID PHOTO ID RECEIVED: _____

ACCOUNT ACTION: : ☐ APPROVED ☐ DENIED

REVIEWER SIGNATURE: _____ ACTION DATE: _____

PRINT NAME (MUST BE LEGIBLE):_____

DENIAL REASON: ☐ USER INFO INCOMPLETE, ☐ OTHER

_____

COMMENTS: